No. 85-1948

Supreme Court, U.S.
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In The

# Supreme Court of the United States

October Term, 1985

GINA DUNNING, Director of the Nebraska Department of Public Welfare; KAY C. ORR, Treasurer of the State of Nebraska; CLIFTON A. SEXTON, JR., Director of Administrative Services,

*Petitioners,*

vs.

THE NEBRASKA HEALTH CARE ASSOCIATION, INC., a Nebraska Nonprofit Corporation; THE EV. LUTHERAN GOOD SAMARITAN SOCIETY, a North Dakota Nonprofit Corporation; W.S.T. CARE, INC., d/b/a CRESTVIEW CARE CENTER, a Nebraska Corporation,

*Respondents.*

## BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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## STATEMENT OF THE CASE

The respondents, who were plaintiffs in the United States District Court for the District of Nebraska, are (1) Nebraska Health Care Association, a trade association, which brought this action on behalf of its members who consist of publicly owned not-for-profit, privately owned not-for-profit, and privately owned for-profit entities which operate skilled (SNF) and intermediate care facilities (ICF), and which are certified providers of medical assistance pursuant to Title XIX of the Social Security Act, 42 U.S.C. Sec. 1396a, *et seq.* (medicaid); (2) The Ev. Lutheran Good Samaritan Society, a not-for-profit corporation, which owns and operates SNF and ICF medicaid certified facilities; and (3) W.S.T. Care, Inc., d/b/a Crestview Care Center, a for-profit corporation, which is certified as an ICF facility. Each of the respondents also brought this action on behalf of the medicaid residents in their facilities.

On May 19, 1983, plaintiffs filed a motion for leave to amend their complaint, alleging four additional causes of action, including, in Counts VII and VIII, allegations that they were deprived of their rights to be reimbursed at rates required by 42 U.S.C. Sec. 1396a(a)(13)(A) and by 42 C.F.R. Sec. 447.252 in violation of 42 U.S.C. Sec. 1983. Upon plaintiffs' motion for reconsideration, the trial court allowed these amendments to be filed on July 19, 1983. The trial of this case occurred on December 19 and 20, 1983.

In the pre-trial order it was stipulated by the parties as a matter of fact, and the trial court found, that the defendant Director of the Department of Public Welfare did not conduct any objective analyses or studies to determine the effects of Sec. 68-720's limitation on the level of care

medicaid patients would receive or the extent to which facilities would continue to participate in medicaid (Petition for Writ of Certiorari, App. 15). The evidence showed, and the trial court found, that the written findings and assurances submitted by DPW to the United States Department of Health and Human Services, Health Care Financing Administration (HCFA) as required by federal law were arbitrary and capricious, and were not entitled to deference (Petition for Writ of Certiorari, App. 15-16). The Court of Appeals affirmed the lower court's injunction of Sec. 68-720 on the same grounds that, there being on factual basis for the State's assurances, the requirements of federal law were not met (Petition of Writ of Certiorari, App. 29).

The evidence adduced at trial showed, and the trial court found, that the 3.75% limitation on reimbursement contained in Section 68-720 was arbitrary and capricious (Petition for Writ of Certiorari, App. 9), and that a large number of facilities were deprived of the rate they were entitled by federal law to receive (Petition for Writ of Certiorari, App. 11). The Court of Appeals determined that it was unnecessary to reach these issues (Petition for Writ of Certiorari, App. 29).

The evidence adduced at trial showed, and the trial court found, that the prorata reduction of previously established prospective rates, pursuant to Section 68-721, *Neb. Rev. Stat.* (Cum. Supp. 1982) arbitrarily and capriciously denied medicaid providers reasonable and adequate reimbursement for expenses which they had to incur as efficiently and economically operated providers (Petition for Writ of Certiorari, App. 17). This portion of the trial court's memorandum and order was not appealed by defendants and is final (Petition for Writ of Certiorari, p. 2).

The trial court, based upon its findings that plaintiffs had been deprived of federal rights under the Social Security Act (Petition for Writ of Certiorari, App. 8 and *supra*), awarded plaintiffs attorney's fees in the amount of $51,195.00 and expenses of $1,078.20 (Petition for Writ of Certiorari, App. 40). The court of appeals affirmed (Petition for Writ of Certiorari, App. 30-31).

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## JURISDICTION IN THE TRIAL COURT

Jurisdiction in the United States District Court for the District of Nebraska, in the first instance, was invoked pursuant to 28 U.S.C. Sec. 1331(a) as an action arising under the Constitution and Laws of the United States.

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## ARGUMENT

### I. THERE IS NO IMPORTANT, UNSETTLED FEDERAL QUESTION REGARDING WHETHER THE CIRCUIT COURT PROPERLY ALLOWED ATTORNEY'S FEES FOR VIOLATION BY THE STATE OF CONDITIONS OF THE SOCIAL SECURITY ACT.

#### A. Attorney's Fees Are Awardable For Deprivations of Rights, Privileges or Immunities Protected by 42 U.S.C. Section 1983.

The plain language of the Civil Rights Attorney's Fees Award Act of 1976 applies to actions arising under

Section 1983 of the Civil Rights Act. 42 U.S.C. Section 1988 provides, in part:

> "In any action or proceeding to enforce a provision of Sections 1981, 1982, 1983, 1985, and 1986 of this Title, . . . the Court, in its discretion, may allow the prevailing party, other than the United States, a reasonable attorney's fee as part of the costs."

*Maine v. Thiboutot,* 448 U.S. 1, 100 S.Ct. 2502, 65 L.Ed.2d 555 (1980), examined this statute and found it clearly applicable to a statutory claim for violation of the Social Security Act arising under Section 1983. The court stated succintly at 448 U.S. 9, 100 S.Ct. 2507, 65 L.Ed.2d 562:

> "Once again, given our holding in Part II, *supra,* the plain language provides an answer. The statute states that fees are available in *any* Section 1983 action. Since we hold that this statutory action is properly brought under Section 1983, and since Section 1988 makes no exception for statutory Section 1983 actions, Section 1988 plainly applies to this suit."

The court also found the legislative history of the Civil Rights Attorney's Fees Award Act to be entirely consistent with the plain language of the act.

> "Representative Drinan explained that the Act would apply to Section 1983 and that Section 1983 'authorizes suits against State and local officials based upon Federal statutory as well as constitutional rights. For example, *Blue against Craig,* 505 F.2d 830 (4th Cir. 1974).' 122 Cong. Rec. 35,122 (1976). Senator Kennedy also included an SSA case as an example of the cases 'enforc[ing] the rights promised by Congress or the Constitution' which the Act would embrace. *Id.* at 33,314. In short, there can be no question that Congress passed the Fees Act anticipating that it would apply to statutory Section 1983 claims."

*Id.* at 10.

Petitioners have cited no contrary authority in their Petition for Writ of Certiorari and apparently do not contest the applicability of Section 1988 to Section 1983 statutory actions.

### B. Rights, Privileges and Immunities Secured by the Social Security Act are Protected by 42 U.S.C. Section 1983.

*Maine v. Thiboutot, supra,* is the controlling authority with respect to the propriety of the Eighth Circuit's affirmance of the Federal District Court's award of attorney's fees in this action. The Social Security Act is a source of federal statutory rights protected by Section 1983. Where state statutes and regulations conflict with the clear requirements of the Social Security Act, 42 U.S.C. Section 1983 applies.

The plaintiffs in *Maine v. Thiboutot* were a husband and wife who had been receiving aid to families with dependent children (AFDC). They claimed the state of Maine's interpretation of 42 U.S.C. Section 602(a)(7) violated that federal law, and they specifically claimed relief under Section 1983. The state trial court enjoined the state defendants from enforcing the challenged rule and ordered them to adopt regulations consistent with federal law. The trial court determined that the plaintiffs were not entitled to bring an action under Section 1983, however, and denied the request for attorney's fees. After the Supreme Judicial Court of Maine awarded attorney's fees, the United States Supreme Court granted certiorari on the question of whether a statutory claim arising under the Social Security Act was a source of rights which was protected

under Section 1983. Affirming the Maine Supreme Judicial Court, the United States Supreme Court held that the Social Security Act was a source of rights cognizable under and protected by Section 1983. This Court stated:

> "The question before us is whether the phrase 'and laws,' as used in Section 1983, means what it says, or whether it should be limited to some subset of laws. Given that Congress attached no modifiers to the phrase, the plain language of the statute undoubtedly embraces respondents' claim that petitioners violated the Social Security Act."

448 U.S. at 4, 100 S.Ct. at 2504, 65 L.Ed.2d at 559.

Respondents in the case at bar pleaded and proved just such a statutory claim. The failure of petitioners to provide reimbursement in accordance with the Social Security Act is cognizable under Section 1983. The Court of Appeals properly applied this protective law in the instant case.

### C. 42 U.S.C. Section 1396a(a)(13)(A) Constitutes a Mandatory Condition for State Participation in the Medical Assistance Program.

In 1980, United States Senator Boren proposed an amendment to Title XIX of the Social Security Act, 42 U.S.C. Section 1396, *et seq.* (Medicaid). The amendment, codified at 42 U.S.C. Section 1396a(a)(13)(A) and hereinafter referred to as the Boren Amendment, provides that a state plan for medical assistance must provide for payment of long-term care services through the use of rates which the state finds, and makes assurances satisfactory to the Secretary, "are reasonable and adequate to meet costs which must be incurred by efficently and economically operated facilities."

It is clear that the Congress, although granting flexibility to the states in rate setting, see *Mississippi Hospital Association v. Heckler,* 701 F.2d 511 (5th Cir. 1983), intended to provide a minimum standard for payment of medical services rendered to qualified medicaid recepients.

One of the purposes of this amendment was to mandate appropriate payment rates to providers. The Conference Committee Report, Section 9, Omnibus Budget and Reconciliation Act of 1980, U.S.Code Cong. & Ad. News 5944 states:

> "The conferees would further note their intent that a State not develop rates under this section solely on the basis of budgetary appropriations. In determining whether the rates proposed by a State are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities, the Secretary is not expected to approve a rate lower than *applicable legal requirements would mandate.*" [Emphasis added]

The Secretary of Health and Human Services adopted regulations in conformity with this Congressional mandate[1].

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[1]42 C.F.R. Section 447.252 requires:

> (a) *Payment rates.* (1) The Medicaid agency must pay for inpatient hospital services and long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.
>
> (2) The payment rates used by the Medicaid agency must be determined in accordance with methods and standards developed by the agency.
>
> * * *

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42 C.F.R. Section 447.252(a) requires the state to pay providers through the use of rates that are reasonable and adequate.

The state of Nebraska accepted the responsibilities of complying with the Boren Amendment when it chose to continue participation in the medicaid program. *Harris v. McRae,* 448 U.S. 297, 100 S.Ct. 2671, 65 L.Ed.2d 784 (1980), discussed the state's obligation to comply with the requirements of the Medicaid Act. While considering the financial responsibility of the state when the Hyde Amendment had denied federal funding for medically necessary abortions, the Supreme Court explained at 448 U.S. 301, 100 S.Ct. at 2680, 65 L.Ed.2d at 794:

> "The Medicaid program was created in 1965, when Congress added Title XIX to the Social Security Act, 79 Stat. 343, as amended, 42 U.S.C. Section 1396, *et seq.* (1976 Ed. and Supp. II), for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons. Although participation in the Medicaid program is entirely optional, once a State selects to participate, it must comply with the requirements of Title XIX."

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(b) *State findings.* The Medicaid agency must find that rates used to reimburse providers satisfy the requirements of paragraphs (a)(1) . . . of this section.

(c) *State assurances.* The Medicaid agency must make assurances satisfactory to the Secretary that the requirements of paragraphs (a)(1), (a)(3)(iii), (b), and (f) of this section are met and that, in making significant changes in its methods and standards for determining payment rates, it has complied with the public notice requirements in Section 447.254.

See, also, *Edelman v. Jordan,* 415 U.S. 651, 94 S.Ct. 1347, 39 L.Ed.2d 662 (1974); *Mississippi Hospital Association, Inc. v. Heckler, supra; Alabama Nursing Home Association v. Harris,* 617 F.2d 388 (5th Cir. 1980).

The Boren Amendment clearly constitutes a condition of participation in the federal medicaid program. *Pennhurst State School & Hospital, et al. v. Halderman,* 451 U.S. 1, 101 S.Ct. 1531, 67 L.Ed.2d 694 (1981), examined the question of whether *Maine v. Thiboutot, supra,* was applicable to a claim brought pursuant to Section 6010 of the Developmentally Disabled Assistance and Bill of Rights Act (DDABRA). 42 U.S.C. Section 6001, *et seq.* The Supreme Court held that, in order to state a claim, the section of the act under which plaintiffs seek to secure their rights must be a condition of the federal-state cooperative funding. The *Pennhurst* decision noted, for example, that in *Thiboutot* the plaintiffs alleged that the state law prevented them from receiving federal funds to which they were entitled. 451 U.S. at 28, 101 S.Ct. at 1545, 67 L.Ed.2d at 714. Section 6010 of the DDABRA, on the other hand, merely expressed findings of the Congress with respect to the type of treatment and conditions of treatment. As the court observed at 451 U.S. at 13, 101 S.Ct. at 1538, 67 L.Ed.2d at 705:

> "Noticeably absent from Section 6010 is any language suggesting that Section 6010 is a 'condition' for the receipt of federal funding under the Act. Section 6010 thus stands in sharp contrast to Sections 6005, 6009, 6011, and 6012."

The Boren Amendment also stands in sharp contrast to Section 6010 of the DDABRA, because the medicaid statute sets forth a mandatory condition of participation by states which seek to receive federal funding.

The Boren Amendment[2] contains the same statutory program language that has been found by this Court to create mandatory conditions of participation under other provisions of the Social Security Act including the medicaid program.

In *Harris v. McRae, supra,* it was another medicaid provision, 42 U.S.C. Section 1396a(a)(17), which the court determined "does require that [a] State Medicaid pla[n] establish 'reasonable standards . . . for determining . . . the extent of medical assistance under the plan which . . . are consistent with the objectives of [Title XIX].'" 448 U.S. at 302, 100 S.Ct. at 2680, 65 L.Ed.2d at 795.

In *Maine v. Thiboutot, supra,* the section of the Social Security Act which the court found was protected by Section 1983 of the Civil Rights Act was 42 U.S.C. Section 602(a)(7), which provides:

> "(a) Contents. A State plan for aid and services to needy families with children must— * * * (7) . . . provide that the State agency — (a) shall, in determining need, take into consideration any other in-

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2 "Section 1396a. State Plans for Medical Assistance. (a) Contents. A State plan for medical assistance must — * * * (13 provide — (a) for payment . . . of the hospital, skilled nursing facility, and intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State) . . . which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards. . . ."

> come and resources of any child or relative claiming aid to families with dependent children, or of any other individual (living in the same home as such child and relative) whose needs the State determines should be considered in determining the need of the child or relative claiming such aid; . . ."

Again, the similarities to the instant case are striking. This Court determined that Section 1983 applied to protect the requirements set forth in a statute which stated the necessary content of the state plan.

*King v. Smith,* 392 U.S. 309, 88 S.Ct. 2128, 20 L.Ed.2d 1118 (1968), involved another action brought under AFDC. In invalidating the "man in the house rule" contained in Alabama medicaid regulations, the Court held:

> "The regulation is therefore invalid because it defines 'parent' in a manner that is inconsistent with Section 406(a) of the Social Security Act. 42 U.S.C. Section 606(a). In denying AFDC assistance to appellees on the basis of this invalid regulation, Alabama has breached its federally imposed obligation to furnish 'aid to families with dependent children * * * with reasonable promptness to all eligible individuals * * * 42 U.S.C. Section 602(a)(9).' "

392 U.S. at 333, 88 S.Ct. at 2141, 20 L.Ed.2d at 1134.

In *Rosado v. Wyman,* 397 U.S. 397, 90 S.Ct. 1207, 25 L.Ed.2d 442 (1970), the court considered a provision of the Social Security Act dealing with AFDC, 42 U.S.C. Section 602(a)(23) (Supp. IV 1968), which provided:

> "[the States shall] provide that by July 1, 1969, the amounts used by the State to determine needs of individuals will have been adjusted to reflect fully changes in living costs and such amounts were established in any maximums that the State imposes on

> the amount of aid paid to families will have been proportionally adjusted."

448 U.S. at 412, 90 S.Ct. at 1218, 25 L.Ed.2d at 454.

After examining the legislative history of this amendment to the AFDC Act, the court determined:

> "We think two broad purposes may be ascribed to Section 402: First, to require States to face up realistically to the magnitude of the public assistance requirement and lay bare the extent to which their programs fall short of fulfilling actual needs; second, to prod the States to apportion their payments on a more equitable basis. Consistent with this interpretation of Section 402, a State may, after recomputing its standard of need, pare down payments to accommodate budgetary realities by reducing the percent of benefits paid or switching to a percent reduction system, but it may not obscure the *actual* standard of need."

397 U.S. at 412-13, 90 S.Ct. at 1218, 25 L.Ed.2d at 456.

Thus, in *Rosado,* although the state had the flexibility of establishing the precise dollar amounts to be paid, they could not circumvent their responsibility of determining and setting forth the actual standard of need. Similarly, in the instant case, the states have some flexibility in establishing the actual level of payment, but they must make payments to long-term care medicaid providers that are consistent with requirements of the Boren Amendment. They are not to be allowed to make payments "lower than the applicable legal requirements would mandate." U.S. Code Cong. & Ad. News, *supra;* see also 42 C.F.R. Section 447.252(a).

Petitioners have not discussed any of these relevant decisions in their Petition for Writ of Certiorari. They do

suggest, however, that the respondents are not the "intended beneficiaries" of the Medicaid Act. Such an argument misunderstands and misapplies the purpose and functioning of medicaid as a federal-state cooperative program.

First, the issue before the Court is the condition imposed by Congress with respect to a particular section of Title XIX, the Boren Amendment. Respondents do not dispute that the ultimate beneficiaries of the entire Title XIX program are the medically and categorically needy. 42 U.S.C. Section 1396. Achieving that ultimate goal, however, requires Congress to structure a workable program that will insure the availability of services, as well as the provision of funds.

A psychiatrist, who challenged state reimbursement regulations on the grounds they conflicted with federal law, was held to have standing to claim the protection of Section 1983 in *Yapalater v. Bates,* 494 F. Supp. 1349 (S.D. N.Y. 1980), *aff'd* 644 F.2d 131 (2d Cir. 1981). The lower court concluded at 1357-1358:

> "Furthermore, within the Section 1983 context, it distorts reality to characterize plaintiff as nothing but a 'provider.' To be sure, it was as a 'provider' that plaintiff furnished Medicaid services; but the case at bar turns upon the legal measure of his reimbursement. Thus he may be just as accurately described as a 'recipient of reimbursement.' He claims that wrongful administration of the Medicaid program by the state deprives him of reimbursement to which federal law entitles him. In my judgment, Section 1983 as interpreted by the *Thiboutot* majority furnishes this plaintiff a remedy."

See, also, *Thomas v. Johnston,* 557 F. Supp. 879 (W.D.Tex. 1983).

Under the terms of the Boren Amendment, providers of hospital and long-term care services are recipients of reimbursement. It is their rates that are directly affected.

Prior to 1972, there was no federally mandated standard of or floor for payment to providers of long-term care services. See *Briarcliff Haven, Inc. v. Department of Human Resources,* 403 F.Supp. 1355 (N.D.Ga. 1975). When Congress adopted the Social Security Amendments of 1972, Section 249(a), it provided the first federal requirements for payments by states to long-term care providers. See *Alabama Nursing Home Association v. Harris,* 617 F.2d 388 (5th Cir. 1980).

In 1980, the Boren Amendment was added to give greater flexibility to the states but without undercutting the purpose of Congress to provide reimbursement rates that were adequate to insure the availability of long-term care services to medicaid recipients. *Mississippi Hospital Association v. Heckler, supra.*

There is a direct and immediate relationship between respondents and the medicaid recipients who are residents of their facilities.[3] Respondents alleged in their complaint

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[3] "In the legislative history of the Social Security Amendments of 1972, Section 249(a), "[t]he Senate Report makes clear Congress' concern over the effect that both underpayment and overpayment have on the quality of care given at long term care facilities." *Alabama Nursing Home v. Harris, supra,* at 392. Then HEW, in its preamble to the regulations amplified Congress' concern when it observed:

> "If facilities are underpaid, because a State's flat rate is unrealistically low or because in determining its rate the State refuses to recognize as allowable costs some of the

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that they were bringing this action, not only on their own behalf, but on behalf of their medicaid residents. Respondents' testimony before the trial court in the instant case, which that court found was not rebutted, established that:

> "The continued use of the [3.75%] limitation would force [nursing homes] either to reduce services to Medicaid patients or to increase the rates they charge to private patients. The former option could prevent them from meeting federal and state licensing and safety standards and could harm their Medicaid patients; the latter places and [sic] unfair burden upon private patients. See *Minnesota Association of Health Care Facilities, Inc. v. Minnesota Department of Public Welfare,* 602 F.2d 150, 154 (C.A. 8th Cir. 1979)."

Petition for Writ of Certiorari, App. 12.

When it rejected the argument that only medicaid recipients were protected by the Boren Amendment, the trial court, in *Thomas v. Johnston, supra,* at 903-904 (W.D. Tex. 1983), stated:

> "The link between the adequacy of reimbursement rates paid to providers and the adequacy of care provided to medicaid recipients is quite obvious."

Given the clear relationship between provider rates and the goal of Congress in providing medical services to

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real costs of providing the services, facilities will be under pressure to cut corners and provide lower quality care, or will be forced to make their non-medicaid patients absorb some of the cost of Medicaid patients' care; at worst, facilities may refuse to accept Medicaid patients. . . ." 41 Fed. Reg. at 27,300.

the indigent,[4] petitioners' argument would leave these "intended beneficiaries" without an adequate remedy. A resident of a nursing home has no standing to challenge the application and enforcement of Social Security Act requirements on long-term care providers. See *O'Bannion v. Town Court Nursing Home*, 447 U.S. 773, 100 S.Ct. 2467, 65 L.Ed.2d 506 (1980); *Geriatrics, Inc. v. Harris*, 640 F.2d 262 (10th Cir. 1981).

Yet, the existence of a private right of action has long been recognized with respect to the Social Security Act. The only other remedy available under the Act is the right of the Secretary of Health & Human Services to withhold federal financial participation from the offending states.

> "We have considered and rejected the argument that a federal court is without power to review state welfare provisions or prohibit the use of federal funds by the States in view of the fact that Congress has lodged in the Department of HEW the power to cut off federal funds for non-compliance with statutory requirements. . . . We adhere to *King v. Smith*, 392 U.S. 309, 88 S.Ct. 2128, 20 L.Ed.2d 1118 (1968), which implicitly rejected the argument that the statutory provisions for HEW review of plans should be read to curtail judicial relief. . . ." *Rosado v. Wyman*, 90 S.Ct. 1222.

397 U.S. at 420, 90 S.Ct. at 1222, 25 L.Ed.2d at 460.

See, also, *Maine v. Thiboutot, supra; Edelman v. Jordan, supra.*

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[4] *King v. Smith, supra,* makes clear that it is the children who are the intended beneficiaries of the AFDC program. "[P]rotection of such children is the paramount goal of AFDC." 392 U.S. at 325, 88 S.Ct. at 2137, 20 L.Ed.2d at 1130. The plaintiffs in *King v. Smith, Rosado v. Wyman, Maine v. Thiboutot,* and other AFDC cases are the parents to whom the payments are made on behalf of the children.

The position of this Court is clear. When Congress makes a portion of the Social Security Act a condition for state receipt of federal funding, that condition may be enforced and the rights arising thereunder protected by suit under Section 1983. There is no important, undecided federal question.

## II. THE CIRCUIT COURTS ARE NOT IN CONFLICT ON THE ISSUE OF WHETHER RESPONDENTS ARE ENTITLED TO ATTORNEY'S FEES FOR VIOLATION OF THEIR STATUTORY RIGHTS UNDER THE SOCIAL SECURITY ACT.

The only other circuit court to squarely address the issue sought to be raised by the Petition for Writ of Certiorari is the Second Circuit. *Yapalater v. Bates,* 644 F.2d 131 (2d Cir. 1981), affirmed the decision of the district court, 494 F. Supp. 1349 (S.D. N.Y. 1980). In that case, a provider of medicaid services brought suit against the State of New York for denying reimbursement under the medicaid program. The court found that it was proper to proceed under Section 1983 for protection of this right and awarded attorney's fees to the provider.

Petitioners rely on *Geriatrics, Inc. v. Harris,* 640 F.2d 262 (10th Cir. 1981), *cert. denied* 454 U.S. 832, 102 S.Ct. 129, 70 L.Ed.2d 109 (1981). This Tenth Circuit decision is distinguishable from the instant case. Plaintiff nursing home had been notified that its medicaid agreement with the state of Colorado was terminated as a result of serious deficiencies in the provision of health services. Plaintiff, alleging it was entitled to a pre-termination hearing, obtained a preliminary injunction from the Federal District Court which allowed it to continue receiving medicaid fund-

ing and accepting medicaid patients. Thus, the gravamen of the complaint was that the petitioner had been denied due process of law. The Tenth Circuit held that the plaintiff's expectation of continued participation in the medicaid program was a unilateral claim or mere expectancy under the rationale of *Board of Regents v. Roth,* 408 U.S. 564, 577, 92 S.Ct. 2701, 2709, 33 L.Ed.2d 548, 561 (1972). Such certification automatically terminated at the end of each one-year period and the burden was on the plaintiff to show that it continued to comply with federal requirements. The Appeals Court found that *O'Banion v. Town Court Nursing Center, supra,* was dispositive of this issue.

There is dicta in *Geriatrics, Inc.* which states that the provider plaintiff was not an intended beneficiary of the medicaid program. This decision, however, predated the decision of this Court in *Pennhurst, supra,* which discusses the function of mandatory conditions in establishing statutory rights which can be protected under Section 1983. The Tenth Circuit Court of Appeals, further, did not review any of the United States Supreme Court decisions discussed above which protect such mandatory conditions under the Social Security Act. Indeed, there is no indication that the plaintiff provider had asserted any conflict between the state medicaid statutes and regulations and the federal law. Because that case asserted no statutory right, it does not conflict with the Eighth Circuit Court of Appeals decision in the instant case.

The only other circuit court decisions discussed by petitioners arose out of the Second Circuit. Petitioners have not completely and correctly analyzed the Second Circuit decisions upon which they have relied. In the first place, the Second Circuit has recognized the propriety of allowing a

medicaid provider to recover attorney's fees for protection of statutory rights under Section 1983. *Yapalater v. Bates, supra.*

Both *Grossman v. Axelrod,* 646 F. 2d 768 (2d Cir. 1981), and *Greenwald v. Whalen,* 609 F.2d 665 (2d Cir. 1979), involved alleged deprivation of due process rights. In each case, the court alluded to the fact that under New York State law the providers did not have a protectable property interest. In *Greenwald,* the court did not determine whether petitioners had a specific protectable right, but simply found that they had been afforded all required due process. In *Grossman,* the discussion of the plaintiff's rights under Section 1983 was dicta, since the plaintiff had not sought the protection of that section. In any event, neither of these cases involved a claim of statutory rights under the Social Security Act.

*Oberlander v. Perales,* 740 F.2d 116 (2d Cir. 1984), on the other hand, did involve allegations that plaintiff provider's medicaid rates had been improperly reduced in violation of the federal medicaid law. But, the plaintiff did not claim that the state law conflicted with federal law. Rather, the plaintiff claimed that the state authorities had failed to follow the state regulations which were consistent with the federal law. The plaintiff argued that because the state medicaid plan had to conform to federal medicaid law, that *ipso facto* state officials' violations of the state regulations were also a violation of federal statutory rights. The court rejected this argument as torturous and noted it would provide a federal jurisdictional basis for every disputed state administrative ruling relating to medicaid.

In *Oberlander,* furthermore, the Second Circuit did recognize that suits under Section 1983 are proper to secure

compliance with provisions of the Social Security Act on the part of participating states, citing *Maine v. Thiboutot, supra.* The court noted numerous federal decisions where jurisdiction did exist involving allegations of a specific conflict between a state plan on one hand and the federal mandate on the other. One such earlier Second Circuit decision, cited in *Oberlander,* was *New York City Health & Hospitals Corp. v. Bloom,* 708 F.2d 880 (2d Cir. 1983). The plaintiff corporation claimed that state medicaid regulations had denied reasonable costs as required by the federal medicaid law. The plaintiff, however, had chosen not to meet its burden of proof to establish that they had not been paid reasonable costs. The court of appeals found that the plaintiff had no standing to raise this issue unless it alleged and was prepared to prove that the disallowances denied it reimbursement for its reasonable costs. In passing, however, the court did recognize that a state plan which was in conflict with federal law would be illegal and would lead to the relief sought by the plaintiff. 708 F.2d at 885.

Petitioners also rely on *White Mountain Apache Tribe v. Williams,* 778 F.2d 1332 (9th Cir. 1985); *Gould v. Wisconsin Department of Industry,* 750 F.2d 608 (7th Cir. 1984), *app. pndg.* 106 S.Ct. 305 (1985); and *Consolidated Freightways Corporation of Delaware v. Kassil,* 730 F.2d 1139 (8th Cir. 1984). None of these cases is applicable to the case at issue and these decisions are not in conflict with the Eighth Circuit decision in the present case. The *Gould* and *White Mountain Apache Tribe* decisions simply stand for the proposition that federal preemption of state law by previous occupation of the field does not give rise to a claim for attorney's fees under the Civil Rights Act. The court in each of these cases reasoned that because the purpose of federal

preemption was to control the relations between the federal and state governments, federal preemption does not establish any protectable right in interested parties. Similarly, the *Consolidated Freightways* decision held that the dormant commerce clause, which also controlled relationships between the federal and state governments, did not establish any protectable interest.

As an analysis of the cases cited by petitioners demonstrates, there is no conflict between the circuits on this issue.

## III. THE COURT OF APPEALS' REVIEW OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES' APPROVAL OF THE STATE PLAN PRESENTS NO IMPORTANT, UNSETTLED ISSUE OF FEDERAL LAW.

The principle that the courts give substantial deference to decisions by the Department of Health and Human Services is not the issue in this case. *Quern v. Mandley,* 436 U.S. 725, 98 S.Ct. 2068, 56 L.Ed.2d 658 (1978), cited at page 39 of the Petition for Writ of Certiorari, does indeed stand for the proposition that:

> "The interpretation of the agency charged with administration of the statute is, of course, entitled to substantial deference. *New York Department of Social Services v. Dublino,* 413 U.S. 405, 421."

436 U.S. at 738, 98 S.Ct. at 2076, 56 L.Ed.2d at 670.

It is equally clear that "substantial deference" does not deprive the courts of jurisdiction to review agency actions. This Court announced in *Citizens to Preserve Overton Park v. Volpe,* 401 U.S. 402, 91 S.Ct. 814, 28 L.Ed.2d 136 (1971), that the courts have a responsibility

to engage in substantial inquiry when reviewing agency actions. Although recognizing the deference due an agency decision, the courts may still reverse if the decision is not based on relevant factors or is a clear error of judgment.

For example, the record before the Court in *King v. Smith, supra,* contained some evidence that the Department of Health, Education and Welfare had approved some sort of "man in the house" restrictions in state plans. While invalidating the state regulations, the Court, at Footnote 34, page 333, observed:

> "It is equally clear that to the extent HEW has approved any so-called 'man in the house' provision which conflicts with Section 406(a) of the Social Security Act, 42 U.S.C. Section 606(a), such approval is inconsistent with the controlling federal statute."

Other courts have reversed decisions of the federal medicaid agency under the generally accepted rules of *Citizens to Preserve Overton Park* and *King v. Smith.* The Eleventh Circuit held in *Alabama Hospital Association v. Beasely,* 702 F.2d 955 (11th Cir. 1983), that the Secretary of Health and Human Services had no discretion to approve a state plan which fails to meet statutory requirements. *Id.* at 962. More recently, *Luverne Geriatrics Center, Inc. v. Baggiano,* 480 So.2d 562 (Ala. 1985), stated at 565:

> "These cases leave no doubt that the Secretary's approval is in no wise a conclusive determination of the plan's validity, but rather, is subject to judicial review. Accordingly, the Court of Civil Appeals erred in finding that the reimbursement plan was in compliance with federal law simply because the Secretary

> of the Department of Health and Human Services had verified the plan."

But, because of the facts of this case, what petitioners are attempting to present is a non-issue. It is not the actions of the Secretary of Health and Human Services which are a problem. It is the actions of the Nebraska Department of Public Welfare.

The relevant facts are not at issue. DPW conducted no objective studies regarding the effect of the 3.75% limitation on medicaid recipients or providers.

Petitioners choose to characterize the undisputed facts as follows:

> "The Circuit Court then adopted an observation of the district court which concluded that the Nebraska Department of Social Services had not conducted objective analyses or studies to sufficiently determine the effect of Section 68-720 (the 3.75% limitation on the level of care) (sic)."

Petition for Writ of Certiorari at 18.

The Federal District Court did far more than make an "observation" about whether the state defendants had "sufficiently determine[d]" the effect of the rate limitation. Judge Urbom's decision, reproduced at Petition for Writ of Certiorari, at App. 15 stated:

> "It is true that the Federal Government approved the State plan which implemented Section 68-720 for 1982 and 1983 and that fact is entitled to deference. It is also true that the Public Welfare Department has special expertise in this area, which means that its assurance to the Federal Government about the adequacy of that plan also should be entitled to deference.

> *But the defendants admit that the Department did not conduct any objective analyses or studies to determine the effects of Section 68-720's limitation on the level of care medicaid patients would receive or the extent to which facilities would continue to participate in medicaid. This means that there is no objective evidence to support the assurances which the Department gave to the Federal Government.* Therefore, the Department's assurances are entitled to no deference. *With no factual basis to support them,* they must be regarded as arbitrary and capricious. This means, then that the Federal Government's approval, which was based on those unsupported assurances, is not entitled to deference." [Emphasis added]

The Eighth Circuit Court of Appeals adopted the lower court's findings, Petition for Writ of Certiorari, at App. 29. The appellate court held:

> "The State's submission of its new plan was simply not accompanied by any information even purporting to meet the requirements of the federal regulation. This fact, without more, is sufficient to invalidate HCFA's purported approval of 3.75% 'cap' for the fiscal year 1982-83. There was no factual basis for the assurances Nebraska submitted to HCFA, and HCFA's approval, being based on unsupported assurances, is without legal effect."

Under these facts, the fault lies with the state. In *California Hospital Association v. Schweiker,* 559 F. Supp. 110 (C.D. Cal. 1982), *aff'd* 705 F.2d 466 (9th Cir. 1983), the state agency did not make an impartial examination of the effect of the medicaid regulations to support its findings and assurances. Instead, it deliberately developed a "best case" support for its position. The court found that the actions of the Department of Health and Human Services in accepting the state's assurances were reason-

able. However, because those original state assurances, themselves, had no reasonable basis they were insufficient to support the state plan. Also, the findings made by the state did not satisfy the requirements of federal regulation. See, also, *Oklahoma Hospital Association v. Oklahoma Department of Human Services,* No. Civ. 83-1274-BT, D.C. Okla., August 24, 1983, CCH Medicare/Medicaid Guide, Para. 33,057, at 10,247; *Thomas v. Johnston, supra,* at 906, 910.

There is no important or unsettled issue of federal law regarding the deference that should be given to the actions of the Department of Health and Human Services.

## IV. THE CIRCUIT COURTS ARE NOT IN CONFLICT ON THE ISSUE OF THE DEFERENCE TO BE GIVEN APPROVAL OF A STATE PLAN BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

*Wisconsin Hospital Association v. Reivitz,* 733 F.2d 1226 (7th Cir. 1984), does not conflict with Eighth Circuit decision in the instant case for the reasons set out in the immediately preceding argument. In addition, there is no conflict in the substance of the two decisions. *Wisconsin Hospital Association* was a review by the Seventh Circuit after entry of an injunction on the motion for summary judgment. The Appellate Court held that the record below had not been sufficiently developed to determine the reasonableness of the rates. The Court observed at 1234:

> "One of the most important elements in determining whether the amended plan complies with the federal criteria would be, if available, a determination by the Secretary of HHS."

The court further expressed its interest at page 1235:

> "Thus, while it is not clear that the state of Wisconsin is required to submit assurances to HHS merely on the basis of a three-month freeze, review by the Secretary would assist the district court in making the sort of factual determinations required in this case."

There is nothing in the opinion to suggest that the Seventh Circuit would be any more impressed with findings and assurances submitted to the Secretary which were not based on any objective studies than was the Eighth Circuit Court of Appeals in the present case.

There is no conflict between the circuits on this issue which would require this Court to grant the Petition for Writ of Certiorari.

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## CONCLUSION

Petitioners have raised no important, unsettled federal question on the issue of awarding attorney's fees which merits a grant of Writ of Certiorari to the Eighth Circuit Court of Appeals. *Maine v. Thiboutot, supra,* and the numerous other cases which have dealt with conditions imposed upon states that accept federal funds support the Eighth Circuit's determination that the Boren Amendment is a statutory basis for protection under Section 1983 of the Civil Rights Act. The award of attorney's fees, therefore, is proper.

There also is no merit in the petitioners' request for review of the rules regarding substantial deference for administrative decisions. The State did not do its job as

required by the federal regulations. Because there were no objective studies to support the state's findings and assurances, there was no basis for the Secretary's approval. Based upon the facts, there is no important issue regarding the rules of deference.

For the reasons set forth in this Brief in Opposition to the Petition for Writ of Certiorari, Respondents respectfully request the Court to deny the Petition for Writ of Certiorari to the Eighth Circuit Court of Appeals.

Respectfully submitted,

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